

PART 1

KENTUCKY HIV TEST FORM

KY Sticker Number	
Session Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Agency Name	
Agency ID Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Client Birth Year (enter 1800 if unknown)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Client State	<input type="text"/> <input type="text"/>
Client County	<input type="text"/> <input type="text"/>
Client Zip Code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Client Ethnicity	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked
Client Race (check all that apply)	
<input type="checkbox"/> American IN/AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native HI/Pac. Islander	<input type="checkbox"/> White <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked
Client Assigned Sex at Birth	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Declined <input type="checkbox"/> Not Asked
Client Current Gender Identity	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	<input type="checkbox"/> Transgender MTF <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Transgender Unspecified
<input type="checkbox"/> Additional (specify): _____	
Previous HIV Test?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	If Yes, what is the client's self-reported result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Prelim. Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked
Date of Last Test: _____ (MM/YYYY)	

Local Use Fields:	
L1 (Testing)	<input type="checkbox"/> 01 General <input type="checkbox"/> 03 Targeted (B) <input type="checkbox"/> 05 CHTC
L2 (Exposures)	<input type="checkbox"/> 02 Targeted (A) <input type="checkbox"/> 04 Targeted DIS
L3 (Rapid Tests)	<input type="checkbox"/> 01 Occupational <input type="checkbox"/> 02 Sexual Assault
L4 (Site Types)	<input type="checkbox"/> 01 OraQuick <input type="checkbox"/> 02 Clearview
Use codes from p.2 of form instructions	

Sample Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	HIV Test 1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Worker Name	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Test Election	<input type="checkbox"/> Anonymous <input type="checkbox"/> Confidential
Test Technology	<input type="checkbox"/> Venipuncture <input type="checkbox"/> Rapid (Use L3 Below) <input type="checkbox"/> Other
Test Result	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result
Result Provided	<input type="checkbox"/> No (Answer next question) <input type="checkbox"/> Yes <input type="checkbox"/> Yes - from another agency
If Results NOT provided, why?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Did Not Return/ Could Not Locate <input type="checkbox"/> Other

Choose status of collection of behavioral risk profile:			
<input type="checkbox"/> Client completed behavioral risk profile <input type="checkbox"/> Client was not asked behavioral risk factors		<input type="checkbox"/> Client was asked but no risks identified <input type="checkbox"/> Client declined to discuss risk factors	
For clients completing a risk profile, did the client report the following behaviors in the past 12 months? (select all that apply)			
	No	Yes	Don't Know
Vaginal or anal sex with a MALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a male without using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a male who is IDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a male who is HIV+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal or anal sex with a FEMALE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a female without using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a female who is IDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a female who is HIV+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal or anal sex with a TRANSGENDER person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a transgender without using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a transgender who is IDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
with a transgender who is HIV+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shared drug injection equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal or anal sex with MSM (female only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Risk Factors:
<input type="checkbox"/> Exchange sex for drugs/money/something they need <input type="checkbox"/> While intoxicated and/or high on drugs <input type="checkbox"/> With person of unknown HIV status <input type="checkbox"/> With person who exchanges sex for drugs/money <input type="checkbox"/> With anonymous partner <input type="checkbox"/> Diagnosed with a sexually transmitted disease (STD) <input type="checkbox"/> Sex with multiple partners <input type="checkbox"/> Oral sex <input type="checkbox"/> Unprotected vaginal/anal sex with a person who is an IDU <input type="checkbox"/> Unprotected vaginal/anal sex with a person who is HIV+ <input type="checkbox"/> Unprotected vaginal/anal sex in exchange for drugs/money/or something they need <input type="checkbox"/> Unprotected vaginal/anal sex with person who exchanges sex for drugs/money <input type="checkbox"/> Unprotected sex with multiple partners

PART 2

KENTUCKY HIV TEST FORM

KY Sticker Number	
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Was the client referred to HIV medical care?		
<input type="checkbox"/> No	Reason the client was not referred to HIV medical care? <input type="checkbox"/> Client Already in Care <input type="checkbox"/> Client Declined Care	
<input type="checkbox"/> Yes	Did the client attend the first appointment? <input type="checkbox"/> Pending <input type="checkbox"/> Lost to Follow-Up <input type="checkbox"/> No Follow-Up	<input type="checkbox"/> Confirmed: Accessed Service <input type="checkbox"/> Confirmed: Did Not Access Service <input type="checkbox"/> Don't Know
<input type="checkbox"/> Don't Know	First medical appointment within 90 days of the HIV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

Was the client referred to/contacted by Partner Services?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	Was the client interviewed for Partner Services? <input type="checkbox"/> No <input type="checkbox"/> Yes, within 30 days of receiving their result <input type="checkbox"/> Yes, but not within 30 days of receiving their result <input type="checkbox"/> Yes, but I don't know within how many days of receiving their result <input type="checkbox"/> Don't Know

Was the client referred to HIV Prevention Services?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	Did the client receive HIV Prevention Services? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know

What was the client's housing status in the past 12 months? (check all that apply)		
<input type="checkbox"/> Literally Homeless <input type="checkbox"/> Imminently Losing Housing	<input type="checkbox"/> Unstably Housed and at Risk of Losing Housing <input type="checkbox"/> Stably Housed	<input type="checkbox"/> Not Asked <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Don't Know

If female, is the client pregnant?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	Is the client in prenatal care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked <input type="checkbox"/> Don't Know

Prior to the client testing positive during this test event, was she/he previously reported to the state's surveillance department as being HIV-positive?			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Not Checked

Date the client reported information
_____ (MM/DD/YYYY)

Has the client ever had a previous positive HIV test?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined	Date of first positive HIV test: _____ (MM/DD/YYYY)

Has the client ever had a negative HIV test?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined	Date of first negative HIV test: _____ (MM/DD/YYYY)

Number of negative HIV tests within 24 months before the current (or first positive) HIV test	
_____ (# # #)	<input type="checkbox"/> Don't Know <input type="checkbox"/> Declined

Has the client used or is the client currently using antiretroviral medication (ARV)?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined	Specify ARV medications: _____ (# #) _____ (# #) _____ (# #) _____ (# #) (use codes on the right)
	Date ARV began: _____ (MM/DD/YYYY) Date of last ARV use: _____ (MM/DD/YYYY)

ARV Medications	
22	Agenerase
30	Aptivus
32	Atripla
24	Combivir
38	Complera
06	Crixivan
37	Edurant
11	Emtriva
03	Epivir
28	Epzicom
25	Fortovase
10	Fuzeon
19	Hepsera
02	Hivid
23	Hydroxyurea
18	Invirase
34	Intelence
36	Isentress
16	Kaletra
31	Lexiva
07	Norvir
33	Prezista
09	Rescriptor
26	Retrovir
15	Reyataz
08	Saquinavir
35	Selzentry
39	Stribild
21	Sustiva
13	Trizivir
27	Truvada
01	Videx
14	Videx EC
17	Viracept
05	Viramune
12	Viread
04	Zerit
20	Ziagen
88	Other
99	Unspecified

General Instructions

1. Use a blue or black ink pen to complete this form.
2. Please print your responses legibly. Unclear and incomplete forms will be sent back to your agency to be fixed.
3. Multiple choice boxes (□) should be clearly marked with a "X" only.
4. Part one of the HIV test form should be completed for everyone who receives a HIV test. Part two of the HIV test form should be completed for everyone confirmed (by Western Blot/IFA) HIV-positive.
5. There are no preprinted Form ID or Client ID numbers. You must adhere or write in the form identification (KY Sticker) number on Part one and, when applicable, Part two of the HIV test form. Do not create your own sticker numbers—these must be obtained from the state HIV/AIDS Branch.
6. To order more KY numbered stickers, call or e-mail Kay.Loftus@ky.gov
7. Mail* completed forms for the current month by the 15th of the following month** to:
CHFS - HIV/AIDS Branch
Attn: Kay Loftus
275 E. Main St., HS2E-C
Frankfort, KY 40621-0001
8. Newly infected HIV cases, confirmed by Western Blot or IFA, are to be reported to HIV Surveillance within 5 business days. Reactive results on a Rapid Test are not reportable until they have been confirmed. (see p.3 for more info)
9. Blank HIV test forms and HIV reportable disease forms can be obtained at <http://chfs.ky.gov/forms>
10. If you have questions or general concerns, please contact us at 800-420-7431

*Agencies completing direct data entry (DDE) into the EvaluationWeb online system should enter data into the system by the 15th of the following month. Forms entered in this fashion should not be mailed to the HIV/AIDS Branch. Instead, keep your entered test forms for one year from the date of the test or in accordance to your agency's record retention policies, whichever time frame is longer. Records ready for expunging should follow HIPAA guidelines for disposal.

**The exception to this rule is if you have a confirmed HIV-positive client, it may take up to 90 days to complete part two of the HIV test form. Part one and part two must be completed and sent in together.

HIV Test Form – Part One

Left-side column:

1. KY Sticker Number
Use KY Sticker as the Form ID
2. Session Date
Date of the HIV test
3. Agency Name
Write out your agency name
4. Agency ID Number
Use your assigned agency number
5. Client's Birth Year
Four digit number. If unknown, enter 1800.
6. Client's State
The state in which the client resides (see p.3)
7. Client's County
The county in which the client resides
8. Client's Zip Code
The zip code in which the client resides
9. Client Ethnicity
Choose one
10. Client Race
Choose all that apply
11. Client Assigned Sex at Birth
Choose one
12. Client Current Gender Identity
Choose one or enter additional identity
13. Previous HIV Test
Choose one; if "yes," indicate previous result and date of last test (if known)
14. Local Use Fields
For fields L1 – L3, choose one
For field L4, use codes from p.2

Right-side column:

1. Sample Date
Date of the HIV test
2. Worker Name
Enter first name and last initial of the tester
3. Test Election
Choose one
4. Test Technology
Choose one
5. Test Result
Choose one
6. Result Provided
Choose one
7. If result not provided, why?
If applicable, choose one
8. Choose One [Risk Profile]
Choose one
9. Table [Client Identified Risks]
Choose all that apply
10. Additional Risk Factors
Choose all that apply
11. Name of HIV Testing Site
Optional, enter where test took place

HIV Test Form – Part Two

1. KY Sticker Number
Use a second KY Sticker (duplicate) that corresponds to HIV Test Form Part One to link these two pages
2. Was the client referred to HIV medical care?
Choose one
If “no,” why was the client not referred into care?
Choose one; move on to the next question
If “yes,” did the client attend the first appointment?
Choose one; move on to the next question if “confirmed – accessed service” was not chosen
If “confirmed – accessed service,” did the client attend the appointment within 90 days?
Choose one; move on to the next question
3. Was the client referred to Partner Services?
Choose one
If “yes,” was the client interviewed for partner services?
Choose one; move on to the next question
4. Was the client referred to HIV Prevention Services?
Choose one
If “yes,” did the client receive HIV Prevention Services?
Choose one; move on to the next question
5. What was the client’s housing status in the past 12 months?
Check all that apply
6. If female, is the client pregnant?
Choose one
If “yes,” is the client in prenatal care?
Choose one; move on to the next question
7. Prior to the client testing positive during this testing event, was he/she previously reported to the jurisdiction’s HIV Surveillance Department as being HIV-positive?
Choose one; move on to the next question
8. Date client reported information for Part Two of HIV Test Form
Enter the date you asked the client the questions on Part Two of the HIV Test Form
9. Has the client ever had a previous positive HIV test?
Choose one
If “yes,” enter a date.
Enter the date of the client’s last previously positive HIV test
10. Has the client ever had a previous negative HIV test?
Choose one
If “yes,” enter a date.
Enter the date of the client’s last previously negative HIV test
11. How many negative HIV tests did the client have within 24 months before current (or first positive) HIV test?
Enter number of tests, if known, or choose “Don’t Know” or “Declined”
12. Has client used or is client currently using antiretroviral medication (ARV)?
Choose one
If “yes,” list current medications.
Choose medication codes from the right side of the page
If “yes,” enter a date when ARV began and date of last ARV use.
Enter the dates according to what the client reports
This form is now complete

Additional Risk Factor Codes

- | | |
|----|---|
| 01 | Exchange sex for drugs/money/or something they needed |
| 02 | While intoxicated and/or high on drugs |
| 05 | With person of unknown HIV status |
| 06 | With person who exchanges sex for drugs/money |
| 08 | With anonymous partner |
| 12 | Diagnosed with a sexually transmitted disease (STD) |
| 13 | Sex with multiple partners |
| 14 | Oral sex |

Local Use Field L4 (Testing Site Types)

- | | | | |
|-----------------------------|---------------------------|------------------------------|-------------------------|
| 01 Inpatient Hospital | 07 Pharmacy/Retail Clinic | 12 HIV Testing Site | 18 Public Area |
| 02 TB Clinic | 08 STD Clinic | 13 School/Education Facility | 19 Individual Residence |
| 03 Substance Abuse Facility | 09 Dental Clinic | 14 Church/Religious Facility | 20 Other Non-Clinical |
| 04 Community Health Center | 10 Correctional Facility | 15 Shelter Facility | 21 HD – Field Visit |
| 05 Emergency Department | 11 Other Clinic | 16 Commercial Facility | |
| 06 Primary Care Clinic | | 17 Bar/Club/Adult Entertain. | |

State and U.S. Territory Abbreviations

AL	Alabama	MI	Michigan	TX	Texas
AK	Alaska	MN	Minnesota	UT	Utah
AZ	Arizona	MS	Mississippi	VT	Vermont
AR	Arkansas	MO	Missouri	VA	Virginia
CA	California	MT	Montana	WA	Washington
CO	Colorado	NE	Nebraska	WV	West Virginia
CT	Connecticut	NV	Nevada	WI	Wisconsin
DE	Delaware	NH	New Hampshire	WY	Wyoming
FL	Florida	NJ	New Jersey		
GA	Georgia	NM	New Mexico		
HI	Hawaii	NY	New York		
ID	Idaho	NC	North Carolina		
IL	Illinois	ND	North Dakota	AS	American Samoa
IN	Indiana	OH	Ohio	DC	District of Columbia
IA	Iowa	OK	Oklahoma	FM	Federated States of Micronesia
KS	Kansas	OR	Oregon	GU	Guam
KY	Kentucky	PA	Pennsylvania	MH	Marshall Islands
LA	Louisiana	RI	Rhode Island	MP	Northern Mariana Islands
ME	Maine	SC	South Carolina	PW	Palau
MD	Maryland	SD	South Dakota	PR	Puerto Rico
MA	Massachusetts	TN	Tennessee	VI	Virgin Islands

Site IDs and Names

If you need to know your Site ID number, you may contact the HIV/AIDS Branch at 800-420-7431.

Disease Reporting to HIV/AIDS Surveillance Branch

1. Report either by phone or mail; do not fax any confidential information
2. When mailing, please place case forms inside of two (2) sealed envelopes, both marked "CONFIDENTIAL"
3. Adult and Adolescents Reporting Form is for ages ≥ 13 , the Pediatrics Reporting Form is for ages < 13
4. Blank forms can be obtained by visiting <http://chfs.ky.gov/forms>

Reports from Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer and Trimble Counties:

- Phone: Susan Delph at 502-574-6570
- Mail: Louisville Metro Health Department
Attn: Susan Delph
400 East Gray St., Rm 317
Louisville, KY 40202

Reports from all other 113 Kentucky Counties:

- Phone: Medina Tipton, Julie Nakayima or Radmila Choate at 866-510-0008 or 502-564-0536
- Mail: Kentucky Department for Public Health
Attn: Medina Tipton
275 E. Main Street, HS2E-C
Frankfort, KY 40621

Additional information on the state regulation regarding reporting is available at <http://chfs.ky.gov/dph/epi/hiv aids.htm>